Coverage Period: On and after 01/01/19

Coverage for: Individual & Family | Plan Type: PPO

The <u>Summary of Benefits and Coverage (SBC)</u> document will help you choose a health <u>plan</u>. The <u>SBC</u> shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <u>azblue.com/GroupPlanDoc2019</u> or call 1-877-475-8440. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>healthcare.gov/sbc-glossary</u> or by calling 1-877-475-8440 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: \$4,000/member and \$8,000/family Out-of-network providers: \$4,500/member and \$9,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 20% <u>in-network</u> and 50% <u>out-of-network</u> .
Are there services covered before you meet your deductible?	Yes. In-network: primary care and specialist office visits, preventive services; prescription drugs, urgent care visits, child eye exams; children's eyeglasses; and children's dental check-ups are covered before you meet your deductible. In-network and out-of-network: emergency room care, emergency medical transportation, and hospice services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network providers: \$7,000/member and \$14,000/family Out-of-network providers: \$14,000/member and \$28,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	<u>Premiums</u> , <u>out-of-network</u> precertification penalty charges, <u>balance bills</u> , and costs for health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket</u> <u>limit</u> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use an in-network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers. Most in-network Arizona providers located only in Maricopa County.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> / p <u>rovider</u> /day, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	Specialist copay for most chiropractic services. Some drugs administered during an office visit may require precertification.
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$85 <u>copay/</u> <u>provider/day,</u> <u>deductible</u> does not apply		\$10 <u>copay</u> for medical telehealth consultations through BlueCare Anywhere.
	Preventive care/screening/ immunization	No charge		Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work) ou have a test	Office visit copay (deductible does not apply) or 20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Cost share varies based on place of service and provider's network status & type. Precertification required for some imaging services. \$500 charge if
	Imaging (CT/PET scans, MRIs)			no precertification obtained for some <u>out-of-network</u> services.

		What You	ı Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.azblue.com	Generic drugs (Level 1)	\$35 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$35 copay/30 day supply & balance bill, deductible does not apply		
	Preferred <u>brand drugs</u> (Level 2)	\$100 copay/30 day supply, deductible does not apply	\$100 copay/30 day supply & balance bill, deductible does not apply	Mail order, Specialty, and 90-day retail supplies of drugs are not covered out-of-network. 90-day supply costs 3 copays (retail pharmacy) or 2 copays (mail order). If generic available, member pays level 1 copay + price difference for brand	
	Non-preferred brand drugs (Level 3)	\$200 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$200 copay/30 day supply & balance bill, deductible does not apply	pays level 1 <u>copay</u> + price difference for brand drug. Some drugs require precertification and won't be covered without it. Only <u>formulary</u> drugs are covered unless a <u>formulary</u> exception is approved.	
	Specialty drugs	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	I /II% coincillance	50% coinsurance	Precertification required for some outpatient services and drugs. \$500 charge if no precertification obtained for some <u>out-of-network</u>
	Physician/surgeon fees		& <u>balance bill</u>	services. Additional \$1,000 access fee for all bariatric surgeries.	
	Emergency room care	\$500 copay, deductible does not apply			
If you need immediate	Emergency medical transportation	20% <u>coinsurance, deductible</u> does not apply		None.	
medical attention	<u>Urgent care</u>	\$85 <u>copay/</u> provider/day, <u>deductible</u> does not apply	50% coinsurance & balance bill		

		What Yo	u Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you have a hospital	Facility fee (e.g., hospital room)	000/	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for some non- emergency services and drugs. \$500 charge, if	
stay	Physician/surgeon fee	20% coinsurance		no precertification for <u>out-of-network</u> stay. Additional \$1,000 access fee for all bariatric surgeries.	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Copay applies to office, home, walkin clinic visits (deductible does not apply). Amount varies based on PCP/Specialist. 20% coinsurance applies to all other locations.	50% <u>coinsurance</u> & <u>balance bill</u>	Cost share varies based on place of service and provider's network status & type. \$20 copay for counseling or \$45 copay for psychiatric telehealth consultation through BlueCare Anywhere.	
	Inpatient Services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required. \$500 charge if no precertification for <u>out-of-network</u> services.	
	Office visits	Office visit copay, deductible does not apply	50% coinsurance & balance bill	Only 1 <u>copay</u> is collected for services included in delivering physician's global charge. Depending	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance & balance bill	on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere	
	Childbirth/delivery facility services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	in SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u> <u>preventive services</u> .	

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Home health care/Home infusion therapy	20% coinsurance	50% coinsurance & balance bill	Precertification required. \$500 charge if no precertification for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year.
	Rehabilitation services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for inpatient facility admission. \$500 charge if precertification not obtained for out-of-network admission. Annual
	Habilitation services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	limits: 90 inpatient days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing
If you need help recovering or have other special health	Skilled nursing care	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Facility (SNF) combined, and a 60-visit limit each for outpatient rehabilitative and habilitative services.
needs	Durable medical equipment	Office visit copay (deductible does not apply) or 20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Cost share varies based on place of service and provider's network status & type.
	Hospice services	No charge	No charge except balance bill, deductible does not apply	None.
	Children's eye exam	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	Limit of 1 routine vision exam/calendar year. No charge for member under age 5.
If your child needs dental or eye care	Children's glasses	No charge	Not covered	Limit of 1 pair of glasses or contact lenses/calendar year.
, , , , , , , , , , , , , , , , , , , ,	Children's dental check-up	No charge	No charge except balance bill, deductible does not apply	Limit of 2 dental check-ups & cleanings/calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care and orthodontic services (Adult) except as stated in plan
- <u>DME</u> rental/repair charges that exceed <u>DME</u> allowed amount
- Experimental and investigational treatments except as stated in <u>plan</u>

- Eyewear except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in <u>plan</u>
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Orthodontic services (Pediatric) that are not dentally necessary

- Private-duty nursing, except when <u>medically</u> necessary or when <u>skilled nursing</u> not available
- Respite care
- Routine foot care
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Bariatric surgery
- Chiropractic care

- Hearing aids, up to 1 per ear, per calendar year
- Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church <u>plans</u> are not covered by the Federal <u>COBRA</u> continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,000
■ Specialist copayment	\$85
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing		
\$4,000		
\$200		
\$1,200		
What isn't covered		
\$60		
\$5,460		

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$85
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cos	\$7,400	
41		

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$110
<u>Copayments</u>	\$2,290
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,460

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,000
■ Specialist copayment	\$85
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$250	
<u>Copayments</u>	\$430	
Coinsurance	\$120	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$800	

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'i' hodíilnih 877-475-4799.

Chinese: 如果您,或是您正在協助的對象,有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題,您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員,請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة للتحدث مع مترجم اتصل ب 877-475-479.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .877-479 تماس حاصل نمایید .

Assyrian:

ي، نِسمة،، نِا سَةِ فِخَوِهِهُ دِهِبَودَهِهِ عَمَاءَ، يَهِكُمَمَةَ، فَوَدَهِهِ حَمَاءَ، يَهِمَاهُ عَلَيْهِ فَع كَهُمَوهِ هِ نَظِيرَ فَعَلَيْهِ فَعَامِهُ فَعَلَيْهِ Blue Cross Blue Shield of Arizona نِسمة، يَهِمَاهُ فَعَام

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยกับล่าม โทร 877-475-4799 Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, cro@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/ portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

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